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The Health Market Inquiry

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07 SEPTEMBER 2018

Dear Pamela and Paulina

PROVISIONAL FINDINGS AND PRELIMINARY RECOMMENDATIONS OF THE HEALTH MARKET INQUIRY – SUBMISSIONS

1. INTRODUCTION

The National Hospital Network ("NHN") refers to the above matter and to the invitation calling for submissions on the Provisional Findings and Preliminary Recommendations of the Health Market Inquiry ("the HMI") announced on 05 July 2018. NHN took note that the HMI requested stakeholders to provide submissions in respect of the proposed recommendations and that submissions should focus on the stakeholder's view of the recommendations, the proposed manner of implementation, the proposed entity responsible for implementing the recommendation, and the proposed timelines.

NHN hereby confirms that the Office acts on behalf of the members that form part of the National Hospital Network. We set out below, our submissions on the HMI.

NHN wishes to thank the HMI Panel for conducting the inquiry and also congratulates them on the sensible approach adopted during the process. NHN is of the view that the inquiry and the interventions proposed are important not only for competition, but in the public interest at large.

Please note that our failure to address any particular issue contained in the HMI in this correspondence should not be taken as an acceptance or a rejection by our members of that issue. In this regard, our members' rights remain reserved.

2. COMMENTS

2.1 COMMENTS ON THE RECOMMENDATIONS FOR FUNDERS

2.1.1 NHN supports the view that Alternative Reimbursement Models (ARMs) should be promoted by funders.

In particular NHN supports the HMI recommendations contained in paragraphs 176 and further of Chapter 10 stating that:

"176. In particular, the Inquiry makes the following recommendation:

*176.1. Sub-rules 7(4) and (5) should be clarified and should allow for **ARMs** such as global fees, subject to certain conditions. Rule 7 should not be considered an all-out prohibition of innovative models. The HMI recommends changes to the wording of this ethical rule in order allow for fee sharing under appropriate circumstances.*

176.2. Rules 8 and 8A should be crafted in a manner that allows multi-disciplinary practices and partnerships, and provide clear guidelines on the grounds that will lead to a ban or prohibition by the HPCSA. The HPCSA should also request the full details of these arrangements in order

to determine whether there are any concerns that arise from them, and to remedy those where appropriate."

NHN agrees that competition in the funders market is neither as vigorous nor as effective as it could, or should, be. NHN also agrees with the findings that there is limited competition between schemes on factors that increase the value of medical scheme cover (in terms of both cost and quality) and limited efforts to design and implement alternative reimbursement models (ARMs) to contain expenditure and encourage value-based contracting and also that schemes have failed to adequately manage supply induced demand.

NHN respectfully submit that the private healthcare industry is willing to consider and implement ARMs but that the process is subjected to factors out of the control of the stakeholders as is stated in paragraph 102 of Chapter 3 stating that: "*Both funders and practitioners have indicated their willingness to adopt new reimbursement models, however there have been legal restrictions to doing so given the HPCSA's interpretation of the ethical rules on sharing of fees (ethical rule 7), business models (ethical rule 8) and subcontracting (ethical rule 18). Regardless, it seems some ARMs have nevertheless been implemented, although there remain some concerns regarding the potential for adverse outcomes".*

NHN expressly supports the view contained in paragraph 47 of the Executive summary that: "*The public hospital system does not provide a competitive constraint to private facilities and individual independent facilities are at a disadvantage when it comes to tariff negotiations, DSPs and* ***ARMs****. As independents, they also do not provide significant competitive constraints. A review of the impact of the exemption granted to NHN suggests that the smaller hospitals have benefited from the exemption."*

Introducing ARMs will in our view generate benefits that ultimately will be in the interest of consumers and funders as was stated in paragraph 476 of Chapter 5 stating that: "*Submissions from both funders and practitioners have indicated that at present remuneration is largely through FFS but acknowledge that*

*introducing **ARMs** and other innovative measures would be beneficial in curtailing rising health costs.",* and also in paragraph 299 of Chapter 6 stating that *Alternative reimbursement models (**ARMs**) are a move away from the standard fee-for-service (FFS) model which characterises the South African healthcare market. The movement from FFS to ARMs is beneficial for both funders, as it provides a level of certainty in costs, and facilities, since the funder would have to compensate for the risk transfer. In addition, ARM arrangements incentivise the hospitals to be sensitive to costs as, unlike in a FFS arrangements, hospital revenues do not necessarily increase with additional services rendered."*

NHN is of the view that any ARM model should be part of a transparent process involving proper consultation with all stakeholders. A lack of proper consultation will in our view constitute poor implementation and an inherent limitation as is envisaged in paragraph 86 of Chapter 3 stating that: "…t*hese models generate positive patient outcomes when incentives are properly aligned but may also lead to undesirable outcomes when models are poorly implemented or have inherent limitations. ARMs differ by the degree of risk-transfer that occurs between a funder and provider."*

Lastly in this regard, NHN supports the recommendation contained in paragraph 144 of Chapter 10 that a phased transition from 'price-only' fee for services (FFS) to reimbursement models (that reward physicians and facilities for value and quality) should be implemented.

2.2 COMMENTS ON THE RECOMMENDATIONS FOR SUPPLIERS OF HEALTHCARE SERVICES

2.2.1 NHN supports the HMI recommendations regarding market concentration

In particular NHN supports the HMI recommendations contained in the following paragraphs of Chapter 10 stating that:

81. *"To further address concentration, the inquiry recommends that the appropriate regulator(s) - in our view, both the SSRH and the PDOHs – develop a set of criteria for assessing local concentration. The assessment framework should specify the maximum allowable level of concentration of private hospitals at the local level. These concentration levels may vary according to local conditions, i.e. available public hospital capacity and insured population capacity"*

and also that:

"83. "*To further address the sale of hospital licences, which we believe materially affects competition and transformation in the sector, we recommend that the sale of licences be jointly notified to competition authorities, the SSRH and the PDOHs. The competition authorities should assess the effect of any sale on competition and the public interest. Given the current concentration in the market all transactions must be notified*."

NHN's support of the aforementioned recommendations are based on our experience that one of the challenges of this market concentration, from a competition perspective, is that it indeed affords the three biggest hospital groups "must-have" status in bargaining for contracts with funders which reduces the countervailing power of funders and also the fact that it also lessens the ability of the smaller groups to compete for more favorable contracts with funders.

NHN also submits and supports the observation in paragraph 56.3 of Chapter 10 that: *"…the merger regime is not effective at identifying and assessing dominance in hospital markets, principally because of the weaknesses in dealing with creeping mergers within the framework of the existing legislation."*

Therefore, and in addition to the aforementioned supported recommendations NHN believes that given the findings on concentration in the HMI **any merger or acquisition or increase in beds** in the healthcare Industry should be jointly notified to and approved by the competition authorities.

We base our submission on the fact that NHN, like the HMI, noted that the well-intended moratorium by the National Department of Health (NDoH) on new hospital licences has fuelled concentration after participants started to use mergers and acquisitions as a way to circumvent licensing restrictions to enter the market.

NHN members are indeed now faced with creeping mergers, a series of acquisitions over time that individually do not raise competition concerns, but when taken together, have a significant impact on competition. Of concern is the fact that the draft Competition Amendment Bill acknowledges the need to address these creeping mergers and the phenomenon of creeping concentration. According to NHN creeping mergers is one of the main drivers of the increased concentration level in the facilities market since the aforementioned moratorium.

In addition to the current legal shortcomings regarding creeping mergers NHN is also concerned about the increased concentration that took place since collecting the data up and until 2014 to date, as a result of transactions that are not notified to the competition authorities for various reasons, including failure to notify by the merging parties, and that they fall under the threshold for notification. The small size of the firms being acquired often results in some transactions being classified as small mergers in terms of the Act and therefore being non-notifiable, despite the fact that the merger may be anticompetitive. NHN believes that these transactions do have an impact on competition following change of control in some instances or in other instances the smaller firms being swallowed up by the big groups. Based on precedent, it is likely that these transactions would be allowed by the Tribunal as the impact on competition would not change given historical links between the firms.

Some international jurisdictions have instituted mechanisms to address creeping mergers either directly or indirectly. Although there is broad acknowledgement that creeping mergers drive consolidation in the South African facilities market, there is at present no explicit clause that competition

authorities can use to address creeping mergers. While amendments have been proposed to address the issue of creeping mergers more effectively, NHN believes that it will take too long to implement and that the Tribunal should in the meantime use its inquisitorial powers to overcome the current legal shortcomings. There is further scope for the Tribunal to use the public interest provisions embedded in the Competition Act, to assess the impact of concentrated markets in the context of healthcare.

Of concern is the unscrupulous way in which these creeping mergers are executed in practise. Aside from the Lakeview and Netcare transaction, that The Competition Commission of South Africa should be aware of, NHN recently got notification from MediClinic South Africa on 24 August 2018 of their acquisition of Welkom Medical Centre, an NHN member, effective 6 days later, *i.e.* on 01 September 2018. As NHN was not aware of any negotiations up and until 24 August 2018 between the parties our member was included in all tenders, proposals etc. The far-reaching implications of this need not be particularised. NHN submits that a strong case can be made that any acquisition of a NHN member hospital by any one of the three large hospital groups should be notified and approved by The Competition Commission of South Africa.

Alternatively to the aforementioned and related to NHN's comments on healthcare capacity planning and the development of a coordinated facility licencing framework dealt with below, NHN is in favour of a further moratorium on issuing licences (new facilities or the increase of beds) for the three large hospital groups, namely, Netcare, Life Healthcare and MediClinic. NHN suggests however that such a moratorium should include acquisitions by these groups to address the phenomenon of creeping mergers dealt with already.

2.2.2 NHN supports the recommendations regarding the establishment of a dedicated Supply Side Regulator for Healthcare (SSRH)

NHN agrees with the view expressed in the HMI that supply side regulatory measures should aim to affect the behaviour or operation of healthcare service providers pertaining to:

- Healthcare capacity planning that governs the number and distribution of providers for current and future needs through mechanisms such as licensing and accreditation;
- Economic value assessment that can ensure rational use of health resources;
- Outcome measurement, registration and reporting aimed at enhancing competition on the basis of improved health outcomes and at value-based payment.

NHN also supports the observation that the current provider side of private healthcare markets unfortunately suffers from several structural, behavioural and regulatory imperfections that harm competition and undermine access to healthcare. Therefore, NHN supports the recommendations pertaining to:

- Healthcare capacity planning including the development of a coordinated facility licencing framework and the implementation of a new practise code numbering system.

  NHN submits that the licensing framework should be based on a comprehensive national plan that takes capacity in both the private and public sectors into account. New licences for both public as well as private healthcare facilities should be issued in line with a national plan and should have regard to *inter alia* the need for competition is the different types of health establishments (including day clinics, hospitals, sub-acute facilities as well as primary care facilities such as dental surgeries, GP rooms and primary care clinics), whether the supply of beds and practitioners bears reasonable relation to the population served, and should prioritise innovative models of care. The national plan and licencing criteria should be developed in a consultative manner with relevant stakeholder representation facilitated by the Department of Health.

NHN supports the recommendations regarding a temporary licence being granted after the supply of information on the proposed site and the market study on the need identified in the geographical area (*i.e.* type of hospital, number of beds etc.). NHN is also in favour of the recommendation that stakeholders should be granted an opportunity to object to new licenses before they are granted.

- Economic value assessment and specifically the development of standards of care, evidenced based treatment protocols and processes to conduct health technology assessments. These health technology assessments can assess the impact, efficiency and costs of medical technology, medicines and devices related to clinical outcomes.

- Outcome measurement and specifically the development by the Outcomes Measurement and Reporting Organisation (OMRO) of a transparent and objective system to monitor the quality and outcome of healthcare services. NHN submits that although some schemes measure these outcomes to a certain degree, the measurement is not uniform and of little help. The development standard metrics will help to analyse the performance of a wide range of facilities and practises. This development process should however include participants from the entire healthcare system to ensure the support of the stakeholders.

NHN supports the recommendation that the requirement to monitor quality should be legally enforceable by the Supply Side Regulator of Healthcare (SSRH) and/or OMRO and also that OMRO should be strictly independent from government and the private sector for it to have credibility amongst providers, patients and funders.

2.2.3 NHN supports the recommendation on an appropriate tariff determination structure and more specifically proposal 1 (one), i.e. the regulated pricing model contained in paragraphs 110 to 122 of Chapter 10.

It serves to mention that NHN fully supports the observation of a tariff vacuum in the private healthcare system that makes it very difficult for schemes, providers and scheme members to estimate and compare the costs of care amongst providers. The causes of this vacuum should not be dealt with in these submissions. In NHN's view the supported regulated pricing solution with multilateral inputs (stakeholder submissions) where after the SSHR can consult with stakeholders, conduct research and then determine FFSs, with PMB tariffs as binding and Non-PMB tariffs to have the status of reference prices will:

- Address the tariff vacuum; and
- Protect the smaller stakeholders (with fewer resources) from very complicated and possibly very time consuming and expensive negotiations.

Unfortunately, the entire process described lacks in detail and it should be noted that NHN's support of this recommendation is only a principle based support and a result of the need to choose between proposal 1 (one) referred to above and proposal 2 (two) described from paragraphs 123 and onwards in Chapter 10 that may prove to be a logistical nightmare, time consuming and costly. Further engagement with stakeholders should take place to clarify the rights, obligations and functions of all stakeholders.

2.2.4 NHN supports the recommendation that coding systems across the sector be standardised.

NHN believes it to be above disputation that coding systems can facilitate meaningful sharing of information that is particularly important in relation to monitoring of quality of care, provider payment, maintenance of coding systems in line with evolving developments in medical care, introduction of new technology, and to prevent unilateral manipulation of codes to adjust tariffs.

NHN supports the observation that coding systems are integral to adoption of provider payment systems and that they are essential to a well-functioning healthcare system, and potentially affect all stakeholders' financial and clinical interests in different ways.

NHN supports the recommendation that management of coding systems should reside within one regulatory body and for purposes of these submissions reside with the same SSRH unit that is responsible for pricing of healthcare services. The SSRH should similarly coordinate the process by engaging stakeholders in executing its research function in this regard. Given that this is a highly specialised area, the SSRH should have the mandate to outsource certain parts of its work to independent experts.

2.2.5 NHN supports the recommendation that the Council for Medical Schemes (CMS) should include metrics of Supplier Induced Service in its published reports.

NHN supports the observation that practitioners are usually the point of entry into the healthcare market. Due to their superior healthcare knowledge, they act as agents for consumers who will not readily differ from the expert. Practitioners are therefore able to influence healthcare expenditure through their own activities, such as diagnoses and treatment, and also through the services and treatments they recommend.

NHN especially supports the recommendation that the CMS should publish publicly what schemes are doing to cut back on supply induced demand.

2.2.6 NHN supports the recommendation that Rule 18 should be written in a permissive manner and should not be interpreted as a blanket ban on the employment of practitioners.

NHN submits that it will inevitably result in more effective healthcare services if private hospitals are able to secure not only partial availability of practitioners but their full time dedication to not only that specific facility but also any programs driven by such a facility to further certain problematic healthcare outcomes, cut back on supplier induced demand, etc.

NHN therefore supports the recommendation that the HPCSA must play an oversight role in employment of doctors but this must be measured and permissive and should specifically look to approve those arrangements where the benefits in terms of cost and quality will accrue to patients. NHN also supports the recommendation that employment of doctors should not be prohibited, but conditional. It will in our view serve all well if the HPCSA undertakes a review of its ethical rules with a view to allow conditional employment of doctors so that unnecessary barriers to innovation and alternative models of care that have a positive effect on health outcomes but prevent revenue maximising behaviour with no demonstrable health outcome benefit, are allowed.

In relation to this NHN support the recommendation contained in clause 176 that Rule 23A should be reconsidered to ensure more effective monitoring of practitioners' financial interest in facilities. Practitioners who own shares in facilities should declare this information to the HPCSA on an annual basis and this information should be published by the HPCSA on its website and all facilities where affected practitioners work.

2.2.7 Recommendations on provider networks and tenders

NHN agrees with the observation that provider networks in general have a net positive impact on competition and should continue to be an option in the sector's drive to provide quality care based on value. NHN also agrees that facility and pathology DSP arrangements, in particular, should be far more competitive than they are at present.

In principle NHN agrees with the recommendation that DSP partners should only be appointed after an open tender process and that results of the process must be lodged with the SSRH and published.

NHN does not agree with the recommendation that DSP contract arrangements should not be longer than two years. Although NHN agrees that evergreen contracts should not be concluded and that testing the market regularly in an

open manner will have a positive effect on competition as well as expenditure in the long run but repeating the process every two years may proof to be impractical.

We submit that alternatives can be considered such as an open network as long as set criteria is met or that the maximum length of DSP agreements should be diversified, allowing for different terms for the respective contracts.

3. GENERAL

3.1 NHN submits that not enough research was done on the issue of central procurement and the effect that it has on the smaller groups. Hospital groups are measured on efficiency by funders and these efficiency scores are relevant when contracts are negotiated to determine networks, preferred service providers etc. The cost of “surgicals” forms an inherent part of these efficiency scores. The bigger groups can procure surgicals in volumes, therefore at cheaper acquisition prices and render them more efficient under the surgicals component of efficiency scores. Their overall efficiency score is in turn better as a result thereof, allowing them to negotiate better tariffs with funders than the smaller groups. It is submitted that the ability to procure centrally has a direct and significant effect on the efficiency of smaller groups and eventually their competitive abilities. This issue can be addressed by allowing smaller groups to procure centrally.

3.2 The introduction of new regulatory bodies such as the SSRH and OMRO are all required as submitted above. Correspondingly the functions of these bodies are justified as also submitted above. NHN is cautious however of the functions and obligations retained by the existing bodies such as The Office of Health Standards Compliance. NHN submits that there should be a clear demarcation to avoid repetition in compliance obligations and administration.

4. CONCLUSIONS

As stated above, the comments set out in this document are not exhaustive of our members' position.

The HMI currently lacks necessary detail in certain aspects to enable meaningful comment on the report, which includes detail of undefined processes that can be implemented in terms of the recommendations. Notwithstanding the foregoing, we endeavoured to comment, as far as possible, on the salient aspects of the report.

Given the vagaries of the report in its current formulation, it would in, any event, be necessary for the public and stakeholders (including our members) to be given a further and proper opportunity to comment on the next iteration of the report. In this regard, a failure to further consult would be fatal to the procedural propriety of the report and is not in the interests of a substantive commitment by the parties to engage constructively on these and related matters.

We accordingly await your response to the comments provided, with reference to meaningful public participation pursuant to both section 33 of the Constitution and the provisions of the Promotion of Administrative Justice Act No. 3 of 2000.

We trust that the above is in order and look forward to receiving your reply.

Kind regards

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